Third Party Liability

Third Party Liability – Commercial Health Insurance and Medicare – Medicaid Payment Guidelines for Third Party Coverage

Federal regulations require Medicaid to be the "payer of last resort". This means that all third-party insurance carriers, including Medicare and private health insurance carriers, must process the claim before Medicaid processes the claim. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

Claims are paid using the lessor of logic which means if the service is covered by Medicaid, Medicare and another health insurance carrier then Medicaid would pay the lessor of Medicare or the other insurance carrier cost-share or the difference between the amount paid by the other insurance carrier and the Medicaid state plan rate.

Certain Medicaid programs are not considered "primary payers" regarding the payer-of-last-resort provision. When a Medicaid beneficiary is entitled to one or more of the following program or services, Medicaid pays first:

- Vocational Rehabilitation Services
- Division of Service for the Blind
- Division of Public Health "Purchase of Care" Programs
    - Cancer program
    - Prenatal program
    - Sickle cell program
    - Children's Special Health Services
    - Kidney program
    - School health fund
    - Tuberculosis program
    - Maternal and Child Health Deliver funds

DMA contracts with various contractors that perform multiple audits and recoveries to ensure that Medicaid is the "payer of last resort".

NC Provider 2057 Insurance Referral Form

Providers are required to submit the NC Provider 2057 Insurance Referral form when they have been notified that the beneficiary has other insurance, including Medicare and private insurance coverage. The form may also be used to update or add policy information. The form is the most efficient way to request that the beneficiary's policy information is updated in a timely manner. Once the form has been submitted the contractor will review, verify policy information and update the beneficiary's policy within 48 hours.

Criteria used to verify and update the policy:

- Medicaid identification number

- Social Security number
- Policy begin and end date
- Group number
- Insured first and last name
- Employer's name
- Employers address
- Reason for the referral
    - The beneficiary's Medicaid eligibility file does not list the policy above
    - Beneficiary has never been covered by the policy
    - Beneficiary's coverage ended (date)
    - Policy lapsed (date)
    - Carrier has changed; new carrier is _____
    - Oher

If all of the required information was not submitted with your request then your request cannot be granted.

To access the referral form click on the following link:

https://ncprovider.hms.com/

Determining Third Party Liability – Commercial Health Insurance and Medicare

The following information helps providers to determine if a Medicaid beneficiary has third-party liability insurance:

1. Check the beneficiary's eligibility for third-party insurance information. Refer to NCMMIS Provider Claims and Billing Assistance Guide. Review Verifying Beneficiary Eligibility Section 10 for additional information on verifying eligibility and checking for third-party insurance. Click the link to access the billing assistance guide. https://nctracks.nc.gov/content/public/providers/provider-manuals.html

2. Before rendering service, providers should ask the beneficiary if she or he has any additional health insurance coverage or TPL, including Medicare. If the health insurance is indicated on NCTracks, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive either payment or a written denial from the insurance company.

3. Check the Remittance and Status Report (RA). When a claim is denied for other insurance coverage (EOB 94), the provider's RA will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number.

If the insurance company or other third-party payer terminated coverage, provider should submit a request for updates to a beneficiary's commercial insurance information electronically via a secured connection. To submit request, please go to https://ncprovider.hms.com/

Contractor for Division of Medical Assistance (DMA), researches third-party insurance information. Electronic request will be reviewed and updated if necessary within 48 hours, and providers may submit electronic claim to Medicaid fiscal agent as soon as the provider receives a confirmation email from the contractor.

As a provider, your role in the TPL process begins as soon as you agree to treat Medicaid and Health Choice eligible patients. You should ask every patient and/ or the patient's responsible party about other insurance coverage. It is the patient's responsibility as well as the provider to update DMA with any changes.

Contracted Fee-for-Service Payments – Commercial Health Insurance

The Medicaid Program makes payments to providers on behalf of beneficiaries for medical services rendered, but Medicaid is not an "insurer." Medicaid is not responsible for any amount for which the beneficiary is not responsible. If the beneficiary is not responsible for payment, then Medicaid is not responsible for payment.

Noncompliance Denials – Commercial Health Insurance and Medicare

Medicaid does not pay for services denied by private health plans due to noncompliance with the private health plan's requirements. If the provider's service would have been covered and payable by the private plan, but some requirements of the plan were not meet, Medicaid will not pay for the service.

The provider and the beneficiary both have equal responsibility for complying with private health plan requirements. If the provider asked the beneficiary if there is coverage with a private plan, the beneficiary did not inform the provider of the existence of the beneficiary's private plan, and the plan's requirements were not met because the provider was unaware of them, then the provider may bill the beneficiary for those services if both the private plan and Medicaid deny payment due to noncompliance. It is the beneficiary's responsibility to inform the county Department of Social Services of any third-party insurance as well as any changes in insurance coverage.

Similarly, if the beneficiary fails to cooperate in any way in meeting any private plan requirements, the provider may bill the beneficiary for the services. However, if the beneficiary presents the private payer information to the providers, and the provider knows that the provider is not a participating provider in the plan and cannot meet any of the private plan's other requirements, then before rendering any service, the provider must so inform the beneficiary that 1) the provider is a nonparticipant in the plan or otherwise cannot meet one or more of its requirements and 2) the beneficiary will be responsible for payment. Medicaid will deny payment due to noncompliance. Common noncompliance denials are:

- Failure to get a referral from a participating primary care provider (PCP)
- Failure to go to a participating provider or outside your employer's plan network
- Failure to obtain a second opinion
- Failure to obtain prior approval

Refunds to Medicaid – Commercial Health Insurance and Medicare

When a provider does not learn of other insurance coverage or Medicare entitlement for a beneficiary until after receipt of Medicaid payment, the provider must submit a refund to Medicaid following the guideline list below.

For commercial health insurance:

1. File a claim with the health insurance company.
2. Upon receipt of payment from the insurance carrier.
3. Adjust the claim via the provider portal if payment was received within the 180 days from the date of service.
4. Complete the NCtracks Provider Refund Form if it has been more than 180 days from the date of service. The form can be found on the following website: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
5. You must ensure that the form has been completely filled out prior to printing the electronic form and send the form along with refund check to the fiscal agent at the address provided below.

For Medicare:

1. Recoup the Medicaid payment, by voiding the initial claim.
2. File a claim with Medicare intermediary or carrier.
3. Upon receipt of payment from the provider for the Medicare payment.
4. Adjust the claim via the provider portal if payment was received within the 180 days from the date of service.
5. Complete the NCtracks Provider Refund Form if it has been more than 180 days from the date of service. The form can be found on the following website: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
6. You must ensure that the form has been completely filled out prior to printing the electronic form and send the form along with refund check to the fiscal agent at the address provided below.

   Unless DMA requests in writing those refunds should be sent to another address, providers send refunds to:

   Misc. Medicaid Payments
   PO Box 602885
   Charlotte, NC 28260-2885

Time Limit Override on Third-Party Insurance - Commercial Health Insurance

All requests for time limit overrides due to a third-party insurance carrier that does not respond within its time limit must be submitted to the TPR section and include documentation verifying that the claim was timely filed to the third-party insurance carrier.

The provider has 180 days from the EOB date listed on the explanation of benefits from the insurance carrier (whether the claim was paid or denied) to file the claim to Medicaid. The claim should be submitted along with the Medicaid Resolution Inquiry Form and EOB in the mail to the fiscal agent.

Medicaid Resolution Inquiry Form can be found on the following website:

https://nctracks.nc.gov/content/public/providers/provider-manuals.html

Credit Balance - Quarterly Reporting

All providers participating in the Medicaid Program are required to submit to the DMA Third Party Recovery Section, a quarterly Credit Balance Report indicating balances due to Medicaid. Providers must report any outstanding credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. However, hospital and skilled level nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy, by Medicare and Medicaid, by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process or if computer billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid Program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider's accounting records (patient accounts receivable) as a "credit." However, credit balances include money due to Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid Program. The provider is responsible for identifying and repaying all monies owed the Medicaid Program.

The Credit Balance Reporting process is moving from paper to electronic. HMS has completed the development of the Self-Disclosure Portal in their eCenter web application. The application will assist with more quickly processing credit balance reports. The application will also benefit providers by reducing cost for postage and paper when submitting paper reports. Once the report has been uploaded it will receive a time and date stamp to confirm when the report was submitted by the provider.

In order to be able to submit credit balance reports electronically, each provider will need to register to use the Self-Disclosure application in eCenter.

1. Navigate to HMS eCenter: ecenter.hmsy.com
2. If you have never used eCenter, please click on the link "Start here for new access"
    a. Fill out the registration form and click submit
    b. You should receive follow up communication from HMS Help Desk. Please inform the Help Desk that you need access in eCenter to the "Provider Portal Provider Overpayment Reporting-NC"
3. If you are a current user in eCenter, please call the HMS Help Desk (1-855-554-6748) to request that your access be updated
    a. Inform the Help Desk that you need access updated in eCenter to the "Provider Portal Provider Overpayment Reporting-NC"

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid Program. You will need to indicate the refund method followed whether you adjust the claim, a check is sent, or you request that DMA adjust the claim for you. An adjustment to the claim via NCTracks is the preferred form of satisfying the credit balance. If you would like DMA to make the adjustment on your behalf, please make sure you report all cost share and overpayment amounts correctly.

Failure to submit Medicaid Credit Balance Report will result in the withholding of Medicaid payment until the report is received.

Instructions for completing the quarterly credit balance report is located on DMA's Website
(DMA Form - 2045)
http://dma.ncdhhs.gov/document/third-party-insurance

Instructions for the formatting of the quarterly credit balance report is located on DMA's Website
(DMA Form – 2044-ia)
http://dma.ncdhhs.gov/document/third-party-insurance

Personal Injury Cases

Tort (Personal Injury Liability)

Medicaid beneficiaries may qualify for other third-party reimbursement because of an accident, illness, or disability. A third party, or other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents, slip and falls, medical malpractice or on-the-job injuries or illnesses not covered by Worker's Compensation.

N.C. General Statute § 108A-57 gives the State subrogation rights; that is the State has the right to recover any accident-related Medicaid payments from personal injury settlement awards as an offset to the cost of Medicaid.

N.C. General Statute § 108A-59 is an assignment of benefits statute. By accepting Medicaid, a beneficiary is deemed to have made an assignment to the State of the beneficiary's right to medical benefits, including both contractual and non-contractual benefits to which the beneficiary is entitled. This includes, but is not limited to, any payments which the beneficiary is entitled from medical payments ("med pay") policy, regardless of the owner of the policy.

Provider's Rights in a Personal Injury Case

When a provider learns that a Medicaid beneficiary has been involved in an accident, the provider must notify TPL Section. If the provider has knowledge of the liable third party at the time of filing the claim, a completed **Third Party Recovery Accident Information Report (DMA-2043)** must be submitted with the claim to DMA's TPL Section at the address shown on the form. A completed DMA-2043 must also be submitted with a copy of the bill when anyone request a copy of the bill. A copy of the form is available on DMA's website at http://dma.ncdhhs.gov/document/third-party-insurance .

The following information is required by the TPL section, and will also assist the provider when filing a claim with the liability insurer:

- Name of liability insurer
- Name of the "at-fault" insured person
- Insurance policy or claim number of the "at-fault" insured person
- Name, phone number and address of the attorney, if any

Note: A copy of a letter sent by an attorney or liability insurer to the provider requesting information will suffice in lieu of the DMA-2043.

Billing for Personal Injury Cases

The provider must choose between billing Medicaid and submitting the bill of charges to the liability insurer. Providers cannot initially file a casualty claim with Medicaid, receive payment, and then submit the bill of charges to the liability insurer (or the beneficiary) from the same service, even if the provider refunds Medicaid.

The provider cannot bill the beneficiary, Medicaid, or the liability insurer for the difference between the amount Medicaid paid and the provider's full charges. (See Evanston Hospital v. Hauck, 1 F.3d 540 [7th Cir. 1993]). Providers who withhold billing Medicaid have six months from the date of the denial letter or receipt of payment from the insurance company to file with Medicaid, even if the end of the six months is after the end of the usual 365-day filing deadline.

In order for the provider to obtain a time limit override, however, the following requirements must be met:

- The provider must have filed the claim with the liability insurer or attorney within 365 days from the date of service
- The provider must have made a bona fide and timely efforts to recover reimbursement from the third party
- The provider must submit documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial

Payment for Personal Injury Cases

When Medicaid payment is received, the provider is paid in full and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and received payment from a liability insurer, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment.

Pursuant to federal regulations and the Evanston case, there is a distinction between private health insurance payments and other liable third-party payments.

Refunds and Recoupments for Personal Injury Cases

If Medicaid discovers that a provider received Medicaid payment and communicated with a third-party payer or attorney in an attempt to received payment for any balance. Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	$100.00
Amount paid by Medicaid	$50.00
Amount paid by attorney/liability carrier	$100.00
Amount to be refunded to Medicaid	$50.00
Amount to be refunded to attorney/liability	$50.00

Estate Recovery

Estate recovery is a federally mandated program, in which the assets of deceased Medicaid beneficiaries are used to reimburse the taxpayers for long term care provided through Medicaid. Funds are recovered from the beneficiary's estate after his/her death to cover the cost of these services.

N.C. General Statute §108A-70.5 gives the state subrogation rights to collect reimbursement from a beneficiary's estate. Estate includes all real and personal property held individually or jointly.

Trust Recovery

Trust Recovery is a Medicaid reimbursement program that is governed by federal Medicaid law. If a disabled Medicaid beneficiary receives assets in an amount that would render the individual ineligible for Medicaid, the individual may maintain eligibility by placing the assets in a Special Needs Trust (SNT)

that meets certain requirements specified in the federal law. This situation commonly arises when a disabled Medicaid beneficiary receives a substantial personal injury or medical malpractice recovery. There are two types of trusts that can be established in North Carolina with a beneficiary's assets: (1) a d4A or "self-settled" SNT, which contains the assets of the beneficiary, or (2) a d4C or "pooled trust," in which the beneficiary's assets are pooled together with assets belonging to other persons and the subaccounts are managed by a non-profit trust organization. Federal law at 42 USC § 1396p(d)(4)(A) governs self-settled SNT's and 42 USC § 1396p(d)(4)(C) governs pooled trusts. In both cases, Medicaid is entitled to reimbursement upon termination of the trust. Trusts established with assets that do not belong to the beneficiary, such as third party SNTs and testamentary SNTs do not require Medicaid reimbursement.

Health Insurance Premium Payments

Payment of Health Insurance Premiums

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid beneficiaries with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, etc. These beneficiaries are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid beneficiaries when the cost of the premium, deductible, and co-insurance is less than the anticipated Medicaid expenditure.

To be eligible for Medicaid payment of premiums, the beneficiary must be authorized for Medicaid and have access to private health insurance through an employer. DMA will pay the premiums only on existing employer-based policies including COBRA, or those known to be available to the beneficiary. Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, co-insurance, or cost-sharing obligations.

Medicaid reviews the case of each beneficiary who meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost effectiveness determination, and notifies the beneficiary and the appropriate referral source.

When DMA determines that a group health insurance plan available to the beneficiary through an employer is cost effective and the beneficiary is approved for participation in the HIPP program, the beneficiary is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the beneficiary voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The beneficiary is not required to enroll in a plan that is not a group health insurance plan through an employer.

Information about HIPP and the HIPP application are available on line at http://www.mynchipp.com/ and through the county department of social services (DSS) office, hospitals, and rural health clinics. A copy of the HIPP Application (DMA-2069) is available on DMA's website at http://dma.ncdhhs.gov/document/third-party-insurance

Medicare Buy-in Unit

Buy-in is the process by which the State Medicaid Program (Title XIX) notifies CMS that Medicaid has accepted responsibility for payment of Medicare premiums for a Medicaid recipient. CMS bills the state monthly for Medicare premium payments.

Individuals who is age 65 or older, who resides in the United State and meet any of the following requirements are entitled to Medicare:

- A United States citizen or an alien who has lived in the U.S. continuously during the 5 years immediately preceding the month he/she applies for Medicare
- A U.S. citizen under the age of 65 and entitled to disability benefits for at least 24 months under Social Security or Railroad Retirement programs. This group includes:
    - Disable workers at any age
    - Disables widows and widowers between the ages of 50 and 65
    - Women age 50 or older entitled to mother's benefits who meet all requirements for SSA disability benefits
    - Individuals age 18 and over who receive Social Security benefits because they became disable before reaching age 22
    - Disabled qualified Railroad Retirement beneficiaries
    - Individuals receiving hemodialysis for kidney failure
    - Individuals receiving renal transplantation for chronic renal disease

Medicaid pays the Part B premiums for all Medicaid recipients known to be enrolled in Part B. Medicaid pays the Part A premium for Qualified Medicare Beneficiaries with "Q" class who are over age 65.

Providers who have been notified that a Medicaid recipient also has Medicare coverage that has not been added to the recipient Medicaid eligibility file the provider should contact the Buy-in unit so that they can initiate the Medicare coverage span being added to the Medicaid eligibility file once the Medicare coverage has been verified at 888-245-0179.

Third-Party Liability- Frequently Asked Questions

1. What is TPL and how does it affect claim processing?

TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto, or other liability carriers. There are state and federal laws, rules and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services before Medicaid is billed. The

TPR Section is charged with implementing and enforcing these TPL laws through both cost avoidance and recovery methods. Therefore, providers who know of the existence of private health insurance are required to seek payment from these third parties prior to seeking payment from Medicaid.

2. Why was my claim denied for EOB 094?

Resubmit claim indicating private insurance payment. If documented insurance denial required submit with claim on the Medicaid Claim Adjustment Form. The form is located on the following website click on the Medicaid Claim Adjustment Request Form under provider forms. https://nctracks.nc.gov/content/public/providers/provider-manuals.html

The TPL database indicates the beneficiary had third-party insurance on the date of service for which you are requesting reimbursement and that this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you must file a claim with that insurance carrier prior to billing the Medicaid program. If you receive a denial that does not indicate noncompliance with the insurance plan, or if you are paid for less than your charges, bill the Medicaid program and, if appropriate, your claim will be processed. If the Medicaid-allowable amount is greater than the insurance payment you received. Medicaid will pay the difference up to the beneficiary's liability as disclosed on the private insurance plan's explanation of benefits (EOB). It is the provider's responsibility to secure any additional information needed from the Medicaid beneficiary to file the claim.

If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

3. How do providers determine the name and the address of the third-party insurance company that is indicated for the beneficiary file?

A description of the Third-Party Insurance Codes is available on DMA's website at www.ncdhhs.gov/dma/provider/tpr.htm

The codes list provides the name and billing address of the insurance carrier for each code that is listed for the beneficiary.

4. What can the provider do when the claim is denied for EOB 094?

Refer to the RA that showed the claim denying for EOB 094. The insurance information including the policy holder's name, certificate number, and a three-digit insurance code are list below the beneficiary's name.

A list of Third-Party Insurance Codes is available on DMA's website at www.ncdhhs.gov/dma/provider/tpr.htm

5. What is considered an acceptable denial from an insurance company?

An acceptable denial is a letter or an EOB from the insurance company or group/employers on company letterhead that complies with the policy reflected in question # 7. Blue E print-outs are acceptable for only North Carolina based plans, provided that the claims on the denial match the claims being submitted. Forward claims for questionable denials to the TPR section:

Division of Medical Assistance

Third Party Recovery

2508 Mail Service Center

Raleigh, NC 27699-2508

If the provider has an acceptable denial or EOB, attach the denial to the claim and Medicaid Resolution Inquiry Form and forward to CSRA:

CSRA

PO Box 300009

Raleigh, NC 27622-0968

6. Why was the claim denied for TPL after the provider included an insurance denial as referred to in question # 5?

Medicaid denies payment for any service that could have been paid for by a private plan had the beneficiary or provider complied with the private plan's requirements.

Examples of common private plan noncompliance denials include:

- Failure to get an authorization referral from a PCP
- Nonparticipating provider
- Failure to obtain a second opinion
- Failure to obtain prior approval

In these circumstances, the provider may bill the beneficiary for these services, provided the noncompliance was not due to provider error, or the provider may appeal to the private plan.

It may be the provider's responsibility to fulfill requirements of the private plans such as prior approval and referral authorization from the PCP.

7. What are the uses of the Health Insurance Information Referral Form (DMA-2057)?

Complete the DMA-2057 Form in the following instances:

- To delete insurance information (that is, the beneficiary no longer has third party insurance but the beneficiary's eligibility information indicates other insurance)
- To add information (that is, a beneficiary never has the third-party insurance that is not indicated in the beneficiary's eligibility information)

- To change existing information (that is a beneficiary never had third-party coverage that is indicated in the beneficiary's eligibility information; the effective date are incorrect, etc.)

To access the DMA – 2057 Form click on the following link

https://ncprovider.hms.com/

8. If the Medicaid beneficiary's private health insurance company pays the beneficiary directly, can the provider bill the beneficiary?

If the amount of the insurance payment is known, the provider may bill the beneficiary for that amount only. The provider may also file the claim to Medicaid indicating the third-party payment amount in the appropriate block on your claim form, and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, the provider may bill the patient the total charges if the provider is unable to obtain the amount paid from either the insurance carrier or the beneficiary.

9. May providers have an office policy that states the provider will not accept Medicaid in conjunction with a private insurance policy?

Yes. A provider can refuse to accept Medicaid for beneficiaries who also have third-party coverage, even though they accept Medicaid for beneficiaries who do not have third-party coverage. However, providers must advise the beneficiary of the responsibility for payment before the services are rendered. The provider must obtain proper consent from the beneficiary for this arrangement prior to any servicers being rendered. The signed form must be in the beneficiary's record.

10. What may providers do when a beneficiary or authorized beneficiary's representative request a copy of a bill that was submitted to Medicaid?

Providers may provide a copy of the bill to the beneficiary or authorized beneficiary's representative even if the provider has already submitted the claim to Medicaid and received payment if you have proper patient authorization. However, the provider can do so only if in compliance with the following requirement. All copies of any bill that has been submitted to Medicaid **must** state "MEDICAID BENEFICIARY, BENEFITS ASSIGNED" in large, bold print on the bill. If the provider provides a copy of a bill that was filed with Medicaid without this language. Medicaid may recoup this payment.

11. When do providers file a claim with CSRA fiscal agent and when do providers file a claims with DMA TPR section?

Send the claim directly to CSRA fiscal agent when:

- The insurance EOB reflects an insurance payment
- There is an insurance denial with the following reason:

- Applied to the deductible
- Noncovered services (meaning the service was not and will never be covered under this policy)
- Pre-existing condition
- Medicare/Medicaid dually eligible
- Benefits exhausted

File the claim directly with the DMA TPR section if the claim includes either a Health Insurance Information Referral Form (DMA-2057) or an insurance EOB indicating any other type of denial not mentioned in the question above and not denied for reason listed in # 6.

12. If the Medicaid beneficiary is required by their private insurance to pay a copayment amount, can this amount be collected up front at the time the services are rendered?

No. The provider cannot bill the Medicaid beneficiary for the private insurance copayment amount unless the Medicaid payment is denied because the service was a non-covered service, and then only if the provider has advised the beneficiary in advance that the services are not covered. The provider must keep documentation in the beneficiary's record that the beneficiary was made aware of this fact before services were rendered.

13. What can providers do when a beneficiary or another authorized person request a copy of a bill that was submitted to Medicaid? (Casualty or liability cases)

Providers may provide a copy of the bill to the beneficiary, a liability insurer, an attorney or other authorized person even if the provider has already submitted the claim to Medicaid and received payment if you have proper patient authorization. However, the provider can do so only if in compliance with the following requirement. All copies of any bill that has been submitted to Medicaid **must** state "MEDICAID BENEFICIARY, BENEFITS ASSIGNED" in large, bold print on the bill. If the provider provides a copy of a bill that was filed with Medicaid without this language. Medicaid may recoup this payment. Providers cannot receive payment from another entity after you have received payment from Medicaid.

14. How do providers determine the amount of refund due to Medicaid when Medicaid pays my claim and subsequently received payment from a liability insurer? (Casualty or liability cases)

Once a provider files a claims with Medicaid and has received payment, the claim has been paid in full. Upon receipt of any payment from the liability insurer or attorney, the provider must return or refund the payment to the payer. By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider's billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both state and federal laws.

Contact Information

Refunds to Medicaid

Misc. Medicaid Payments
P.O. Box 602885
Charlotte, NC 28260-2885

Overnight Address for Medicaid Refunds

Misc. Medicaid Payments
Lockbox Services (602885)
1525 West W.T. Harris Blvd. – 2C2
Charlotte, NC 28262

Refunds to Health Choice (NCHC)

Misc. NCHC Payments
P.O. Box 602861
Charlotte, NC 28260-2861

Overnight Address for Health Choice (NCHC)

Misc. NCHC Payments
Lockbox Services (602861)
1525 West W. T. Harris Blvd. – 2C2
Charlotte, NC 28262

Medicaid Casualty Lien Request

P.O. Box 31803
Raleigh, NC 27622
Phone: 855-753-2177
Fax: 919-714-8574

Medicaid Casualty Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Medicaid Estate Recovery

P.O. Box 18869
Raleigh, NC 27619
Phone: 866-455-0109
Fax: 919-424-2851

Medicaid Estate Recovery Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Trust Recovery

P.O. Box 18869
Raleigh, NC 27619
Phone: 919-424-2800
Fax: 919-424-2851

Trust Recovery Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Third Party Liability Unit
Division of Medical Assistance

2508 Mail Service Center

Raleigh, NC 27699
Phone: 919-814-0240
Fax: 919-814-0038

Buy-In Unit

2508 Mail Service Center
Raleigh, NC 27699
Phone: 919-814-0217
Fax: 919-814-0038

Paper Claims

CSRA
P.O. Box 300009
Raleigh, NC 27622-0968

Please note: All claims are expected to be submitted electronically to NCTracks. However, if paper version of claims are permitted under State policy, they should be mailed to the address provided above.

Overrides for Third Party Liability and Time Limit

Attention: TPL Unit
2508 Mail Service Center
Raleigh, NC 27699
Fax: 919-814-0038

Health Insurance Premium Payments (HIPP)

http://www.mynchipp.com/

CusttomerService@MyNCHIPP.com

Phone: 855-696-2447

Paper Credit Balance Reports

2508 Mail Service Center
Raleigh, NC 27699

Please note: All reports are expected to be submitted electronically to HMS eCenter web application. However, if you do not have access to the internet you may mailed to the address provided above.